TO: Eliot Fishman
Director State Demonstrations Group
Center for Medicaid and CHIP Services
Center for Medicare & Medicaid Services

Re: Oregon 2017-22 1115 Waiver Renewal

Mr. Fishman,

Thank you for the opportunity to provide comments regarding the application for renewal of Oregon's 1115 Demonstration Waiver. FamilyCare Health is the second largest coordinated care organization in Oregon, operating under the currently approved 1115 Demonstration Waiver. After reviewing the Oregon Health Authority's (OHA) application, overall we are supportive of the concepts and the goals expressed. We support, and recommend approval of the plan to continue with the program in its current form for another 5 years. The Coordinated Care Organization (CCO) model has shown significant progress and has achieved many key accomplishments in furthering the transformation of health care across the state, but the work is not yet finished. It is important that CCOs feel confident the program will not see significant changes within the 2017-22 waiver in order to continue to further the goals of transformation.

We also generally support the concepts outlined as new proposals in the waiver. We appreciate the focus and emphasis on furthering integration of behavioral health services. We know the integration of care is essential to improving outcomes for members. We are very pleased to see social determinants of health and health equity are prominently called out as key strategies to be incorporated into the waiver, particularly housing. We know there is significant evidence showing that housing is a key component to improving health care and reducing costs to the system.

While we generally support the direction the waiver is pointing the Oregon Health Plan, and healthcare transformation, we do have concerns about some of the new proposed concepts. Our goal is to support Oregon's transformation and we would like to see more detailed plans and frameworks proposed in the waiver to ensure that these new initiatives will meet with success upon implementation.

## Flexible Services in Global Budgets

We very strongly support the request in the waiver application to redefine flexible services as "health-related services," and to designate these funds as medical expenses for the purpose of calculating CCO reimbursement rates. The current waiver, which designates these expenditures as administrative expenses for the purposes of rate calculations, has created a disincentive for CCOs to broadly invest in flexible services initiatives. We also strongly support clarifying and making a distinction regarding individual and community based "health-related services."

We do note that it is not clear under the application whether CCOs will be held accountable for any specific requirements with respect to providing health-related services at the individual or community level. If so, we request CCOs be provided with this information, including benchmark expectations, well in advance of the requirement being implemented so that the CCOs may adequately plan. In addition, we would expect that global budget calculations and reimbursement rates would reflect any minimum

requirements for "health-related services" investments imposed on CCOs, and we recommend that CMS include this requirement in its approval of the proposal.

We support the proposal to track health-related services separately from other general medical services expenditures; however, we note that in order to be truly fair and effective the state must create a transparent reporting mechanism that accurately and uniformly reflects such expenditures across the CCOs, taking into account the various business structures and risk accepting entity relationships for the different CCOs. The state's current data collection and reporting mechanisms fail to take into account known related-party arrangements within the various CCO business structures that materially impact the uniformity and comparability of state-prepared and publicly disseminated information. We urge CMS to work with the OHA to provide guidance about acceptable reporting methods and global budget calculation methods that will meet the actuarially sound requirements under federal rules, result in fair and equitable treatment across all CCO's and ensure compliant use of state and federal funds.

## Value-based Purchasing Requirements

We support the general proposal and concept of increasing the use of value-based purchasing (VBP) arrangements. We do note, though, that 13 of Oregon's 16 CCOs are participants in the Comprehensive Primary Care + initiative, and in general, all of the CCOs have some form of alternative payment methodology and/or VBP already in use. We urge CMS to consider this when discussing the VBP proposal with the OHA to ensure that nothing in the waiver would interfere with the CPC+ program requirements, or other non-fee-for-service payment mechanisms already in place. We also strongly request that CMS not approve any VBP proposal that would impose strict requirements on the structure of a VBP mechanism. A one-size-fits-all approach to VBP implementation would be harmful to the state, and the state's providers. We request that CMS ensure the ability to innovate and design and tailor VBP arrangements to suit particular providers is preserved.

## Quality Incentive Program

Oregon's CCOs have been evaluated on numerous quality metrics since the approval of the current 1115 Demonstration Waiver. In addition, CCOs that meet a minimum number of their quality metric targets receive an incentive payment as a reward. Therefore, the concept of a quality incentive program is not new. We do notice the waiver application states that the OHA is interested in adopting more transformational and outcome-based measures as opposed to traditional health care process measures. While we are excited to be a part of health care transformation, and we welcome opportunities and flexibility to allow us to become more innovative in how to deliver quality services in efficient and cost-effective ways, this proposal raises some concerns.

First, the data needed to measure and evaluate performance on required metrics typically comes from providers. We are hearing from our contracted providers that there are already too many metric reporting requirements between Medicare, Medicaid, CPC classic, individual payer requirements, etc. Providers are reporting metric burnout. We believe, rather than adding new additional, unique to Oregon Medicaid, reporting requirements, the state should be working to streamline and align the metric reporting requirements for providers.

Second, while we support attempts to measure the progress of transformation, and the impact of the CCO delivery system in areas outside of health care, we are concerned about such metrics being tied to incentive payments. We agree that the Oregon CCO model is having significant impact on the overall health and well-being of members, and that there is further potential for CCOs to address the social determinants of health. However, it is important to remember that there are numerous other factors also impacting an individual's health and well-being, and some of these factors cannot be influenced by a CCO. We are concerned that, with the types of new quality metrics referenced by the OHA in the waiver application, CCOs will be expected to produce outcomes in areas outside our expertise as health care delivery companies. We would support aspirational metrics in these areas, as well as requests to collect and report as much of this data as possible to study and learn, but at this time we do not support tying incentive payments to such metrics.

Margin Augmentation

In addition to the proposed changes to the standard quality incentive program already in use, the OHA also proposes in the waiver application to revise the CCO global budget methodology with a performance incentive program component. The waiver application refers to this concept as "margin augmentation," we have also heard the OHA present it as "gain augmentation." The submitted application specifically states that details of this proposal still need to be developed. We request that CMS not approve this proposal. Our concern is that the proposal appears to be overly complex, indicating that CCOs would be measured and scored on quality and efficiency, the details of which are not yet developed. We are also concerned this creates a subjective component for the rate-setting process, and that it would not meet the actuarial soundness requirements under federal rules. The global budget process should be an objective, transparent methodology. We are not supportive of the OHA implementing such a process, particularly when we believe the OHA is currently not transparent in its rate setting process.

In alternative to the proposed margin-augmentation scheme, we urge CMS to require the OHA to make publicly available the data currently used, as well as the methodology currently used, to determine the CCO global budgets. In addition, we urge CMS to require the OHA to ensure the data reported by, and used for each CCO is comparable, and that it takes into account risk accepting entities and related party transactions. Lastly, we urge CMS to require that the OHA certify the rates are actuarially sound at the individual CCO level, not at the regional level.

Overall, we note and recommend that for any MLR, rate calculation changes, and incentive payment changes, to be truly fair and effective the state **must** create a transparent method of analysis that truly treats the expenses and profits of the CCOs the same. This includes ensuring that related party transaction are included and considered appropriately in the analysis. As noted above, the state's current data collection and reporting mechanisms fail to take into account known related-party arrangements within the various CCO business structures that materially impact the uniformity and comparability of state-prepared and publicly disseminated information. We urge CMS to work with the OHA to provide guidance about acceptable reporting methods and global budget calculation methods that will meet the actuarially sound requirements under federal rules, result in fair and equitable treatment across all CCO's and insure compliant use of state and federal funds.

Strategies to Expand Access to Person-Centered, Coordinated Care for Vulnerable Populations

We are generally supportive of the proposals within the waiver application that would expand access to person-centered and coordinated care for individuals in vulnerable populations. In particular, we would like to highlight our support, and recommend CMS approval, of the concepts below:

- We support expanding access to nurse home visiting programs and the expansion of targeted case management (TCM) codes to directly bill Medicaid for defined services.
- We strongly support the request to waive the requirement that doulas be supervised by a licensed medical provider when the doula is providing services within her scope of practice. This requirement is currently a significant hurdle we face with respect to expanding access to doulas. Minnesota has already demonstrated the significant positive impact doulas have on outcomes for pregnant women in the Medicaid population, as well as the potential for significant cost savings. We expect any flexibility we have with respect to providing access to and paying for doulas will help us show enormous returns on the investment.
- Similar to doulas, we believe traditional health workers (THWs) are an important part of health care transformation. We urge CMS and the OHA to consider waiving any supervision requirements similar to those for doulas to further the use of, and payment for, THW services.

<u>Coordinated Health Partnerships (CHPs)</u>

We strongly support the goal of using health care dollars to pay for supportive housing services because we know it is wasteful to spend money treating a person to get healthy if that person does not have a home to go to that will help them stay healthy. We would like to note, though, that CCOs are already able to spend flex services funds on supportive housing services, and many CCOs have ongoing relationships with the partners outlined as members of the CHPs.

However, there have been some practical barriers to using funds on these services, such as a need for clear guidelines about what limitations exist (e.g. how many days of rental assistance is acceptable). Additionally, under the current waiver flexible services expenses actually count against a CCO when rates are set because they are calculated as administrative expenses. We do see that this current waiver application includes items to address these issues and thus remove these barriers.

If the CHPs do go forward, there is a lack of specificity and detail in the waiver application. The implementation of the CHPs will be an extremely heavy lift. It will hold CCOs, as the lead entity of the CHPs, accountable for ensuring these services are provided. As such, we want to ensure a solid plan is in place with regard to how implementation will be accomplished prior to implementation taking place. We request that CMS not approve the CHP proposal without detailed answers to the following questions.

- It is indicated that CCOs will be lead entities in the CHPs, however what is the expectation for the relationship between the CCOs and the other partners in the CHPs?
- How many CHPs will be expected to operate within a service area?
    - If multiple CCOs operate in a service area will there also be multiple CHPs, or will there be one CHP with multiple CCOs?

  - If there will only be one CHP in each service area, if multiple CCOs operate in that service area will the CCOs have to compete to be a part of the CHP? If so, how will the performance and metrics of the CCO not included in the CHP be affected?
  - We recommend that CHP service areas overlap with existing CCO service areas, and that only one CHP operate within a service area to minimize the burden on partner entities. In a situation where more than one CCO operates in a service area, we recommend that all CCOs be equal partner leaders of the CHP.
- How are CCOs expected to pay for the services provided through the CHP?
  - Will the CCO global budget include rates for housing services?
  - Will the federal funds provided to implement the CHPs also be used to pay for the services provided through the CHPs?
  - Will the CHP rather than the CCO be responsible for paying for the services? If so, how will the CHP be funded?
- What requirements will the CCOs be held to with respect to the CHPs?
  - The draft document indicates the state will develop a robust accountability framework, however this framework must be in place and ready to implement at the time CHPs are expected to begin planning implementation. All CCOs need to be included in discussions and decisions about the accountability framework created.
  - Will the framework account for barriers faced by the CHPs due to the physical lack of housing? A CHP cannot be held accountable for not meeting its requirements if this is due to not having housing available to transition and support individuals into.
  - The application includes proposed outcomes that will be assessed for the CHPs. Several of these proposed outcomes are beyond the control of a potential CHP. Some depend on the physical availability of housing, and others simply appear beyond the scope of what a CHP can be held accountable for. We support evaluating whether the implementation of CHPs has any impact in these areas, but we request that CHPs not be assessed on outcomes such as: retention in housing unit for 12 months or longer, increase in percentage of adults accessing employment and benefits services, and increase in the percentage of individuals that transition to affordable housing (market rate housing/community housing placement).
- We see mention of short-term rental assistance, up to 60 days, in this application. However, we request and recommend that CMS approve authority to provide long-term rental assistance of up to 12 months. We know it takes significant amounts of time to get individuals stabilized and settled into housing. For a person going from homeless into housing, before he/she can be expected to take on the responsibility of maintaining their housing for themselves, they need time to stabilize and address any health conditions and time to search for and secure employment which will allow them to take over the payment of their rent and utilities themselves. Short-term assistance will not have the necessary impact to truly get an individual into a stable and permanent housing situation.

<u>Sustainable Rate of Growth and Reinvestment of Shared Savings</u>

We strongly support the request to exclude high cost, emerging drug therapies from the sustainable rate of growth calculations. Unfortunately, there are several new and emerging drug therapies that,

while highly effective, are becoming cost-prohibitive. If these costs are not excluded from the sustainable rate of growth test, the state will either not be able to stay within its committed rate of growth, or criteria will have to be put in place to limit the number of individuals eligible for these drug therapies.

The submitted application includes a proposal for the medical loss ratio (MLR) that would create an 88% target MLR, with a requirement for a CCO achieving an MLR between 85% and 88% to reinvest the difference back into the community. At this time it is our understanding that the OHA will not pursue that proposal and instead will impose an 85% MLR with a request for CMS to approve it as a 3 year average, meaning that over a 3 year prospective period (beginning on the date the 85% MLR is first imposed) a CCO must average an 85% MLR. We support this new proposal and recommend that CMS approve it.

In closing, we are generally very supportive of the Oregon 2017-22 1115 Demonstration Waiver application. We are concerned, though, that there is a lack of important details for some of the key proposals at this stage. We request that CMS require the missing details be presented prior to final approval, and that CMS require the OHA to demonstrate key stakeholders have been actively engaged in developing these details.

We request that CMS seriously consider our comments, and the questions we have raised. We look forward to continuing our work as a CCO and to furthering the transformation of health care in the state of Oregon.

Thank you,

Jeff Heatherington
CEO

CC: Lori Coyner, Director Oregon Medicaid Program
Lynne Saxton, Director Oregon Health Authority
Jeremy Vandehey, Health Policy Advisor to the Governor